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St. Bartholomew's Hospital Journal,

MAY 14th, 1898.

"Æquam memento rebus in arduis
Servare mentem."—*Horace*, Book ii, Ode iii.

The Treatment of Pneumothorax.

By SAMUEL WEST, M.D., F.R.C.P.

NO one can foresee the occurrence of pneumothorax. All that can be done by way of prevention is to caution those whose lungs are diseased against any violent muscular or respiratory effort. When pneumothorax has occurred the mischief is achieved. All that treatment can then do is (1) to relieve the symptoms which have been produced, (2) to prevent as far as possible the complications which may arise, or (3) if they arise to deal with them as circumstances require.

The gravity of pneumothorax is not due to the entrance of air into the pleura merely, for if the air be pure—*i. e.* not infected—it may be completely absorbed, and no inflammation of the pleura follow. It depends in the early stage upon the sudden embarrassment of the respiration and circulation consequent on the collapse of the lungs, and in the later stages upon the inflammatory conditions which follow. The treatment may be considered in relation to these two stages, the early and the late.

I. THE EARLY STAGE.—The prominent symptoms of the early stage are shock, pain and distress, and dyspnoea.

The **shock** is often profound. It must be treated on general principles, and for this purpose the rapidly diffusible stimulants are the most useful, *e. g.* sal volatile, ether, alcohol, and strychnia, given by the mouth, or if necessary by subcutaneous injection.

The **pain** and **nervous excitement** should be allayed by sedatives, of which opium and morphia are the most trustworthy. These also may be given by the mouth or *sub cutem*, according to the requirements of the case. The bromides, chloral, cannabis indica, &c., are too slow in their action to be of use where the symptoms are severe.

It is **dyspnoea** which is the chief symptom, and this is usually extreme.

In the cases in which dyspnoea is absent, slight, or at any rate not extreme, the treatment should be general, and the less active the better. The patient should be kept quiet in bed, talking should be prevented, and all muscular effort forbidden. The minor symptoms that present themselves should be relieved by appropriate means, *e. g.* restlessness and excitement by sedatives, such as bromides and chloral, and pain by counter-irritation, local anodynes, or even a few leeches applied to the seat of pain. Great care should be taken to avoid chill, and the case should be carefully watched—first for the signs of congestion of the opposite lung, and secondly for the development of fluid on the side affected.

If the dyspnoea is considerable something must be done, and that without delay. The dyspnoea, as already explained, is partly mechanical and partly physiological, *i. e.* mechanical

so far as the pneumothorax leads to the complete collapse of the one lung and the partial collapse of the other; physiological on account of the embarrassment of the circulation and respiration which this sudden collapse produces. The collapse of the lungs, though the result of their own elastic retractility, is rendered more complete by the increased intra-pleural pressure on expiration. These mechanical factors in the dyspnoea could, in part at any rate, be removed if an exit for the air were provided from the pleura.

If, then, the dyspnoea be urgent the side should be tapped, and the tension thus relieved. For this purpose an aspirator is not necessary or desirable, for, the expiratory pressure being in excess of that of the atmosphere, the air will readily escape of itself during expiration; while if an aspirator be used in the early stages of pneumothorax air will be sucked in afresh from the lung through the original perforation, and the hole be thus kept open. This would be a direct disadvantage, for it is good that the lung should remain collapsed for a while, so as to give the perforation time to close and heal.

There are objections also to the use of a simple cannula, for air will then enter on inspiration as well as escape on expiration, and the risk of some infective substance being introduced from outside into the pleura will be increased. To obviate this objection various forms of valvular cannulae have been proposed, but there is always difficulty in keeping these valvular cannulae clean. The syphon is the safest and best arrangement, *i. e.* a cannula with a tube attached, the end of which is placed under water. In this way a water-valve is formed, which, while permitting the free exit of air, prevents its return.

Paracentesis almost always gives great and immediate relief, though the relief may be unfortunately only of short duration. If the air re-accumulate, and the symptoms return, another paracentesis will be required, and perhaps even a third, fourth, or more.

For such cases as these, where repeated paracentesis is necessary, it has been proposed to insert a cannula, generally a valved cannula, and to leave it in the side. If such a method were employed it would be best to use the syphon arrangement already recommended under water. I think, however, that to leave a cannula in the chest is bad practice, for it is difficult to keep such cannulae clean, and suppuration almost always occurs in the puncture round the tube if it is left in the lung. The cannula then becomes loose, and when it is removed the orifice may not close. An external opening may become necessary; but if so it should be made deliberately after careful consideration, and not permitted to develop accidentally. If repeated paracentesis is necessary, it is best to tap in the usual way and choose a different place each time. The strictest antiseptic precautions should always be taken, for they are, if possible, even more important in paracentesis for pneumothorax than for

pleuritic effusion, inasmuch as the result of purulent infection is so much more serious.

In the cases which require repeated paracentesis free incision of the side may seem indicated.

Free incision would almost certainly be followed by sup-puration, and the case be converted into one of pyopneumothorax, or rather of empyema. If all cases of pneumothorax ended, as a matter of course, in purulent effusion, this would make no difference, and free incision at once might be the simplest and best method of treatment. We know, however, that in some cases of pneumothorax no effusion takes place at all, and that in the rest the effusion is often serous. As the ultimate prognosis of pneumothorax depends largely upon the nature of the effusion, it follows that free incision should be avoided if possible. I should, however, not hesitate to recommend incision if I thought it necessary, rather than run the risk of prolonged dyspnoea. Fortunately, the cases in which the question would arise are likely to be few.

If the dyspnoea increases in spite of repeated paracentesis, it must depend upon other conditions, which are physiological rather than mechanical, *viz.* upon the congestion of the opposite lung, and the consequent embarrassment of the heart.

To relieve these symptoms dry cups may be applied to the interscapular spaces and to the whole back, and this often gives marked relief; or the blood may be detained in the extremities—for example, by an elastic band tied round one or both thighs, or by the use of Junod's boot.

In some cases wet cups may be employed instead of dry; but if there is thought to be an indication for bleeding, the desired result will be better obtained by free venesection. Indeed, we have in certain cases of pneumothorax the very indication for bleeding, *viz.* a right ventricle which is becoming paralysed from sudden over-distension.

Where the pneumothorax occurs in a person whose previous health has not been impaired to any great extent, there are none of the general contra-indications which in other cases may render it of doubtful expediency. If bleeding be decided on, a large vein should be opened, and several ounces of blood rapidly removed. I have no doubt that life might be sometimes saved by timely venesection, and it is certain that bleeding is not as much employed in these urgent cases as it ought to be.

At the same time, whether bleeding be performed or not, the general strength should be maintained in every way, and the heart stimulated by alcohol, strophanthus, citrate of caffeine, or even digitalis, while the general excitement and distress should be allayed by the cautious use of opium or morphia.

II. THE LATER STAGES.—When the urgency of the symptoms has passed off the treatment must be expectant. What is to be done chiefly depends upon whether effusion follows or not.

If no fluid form, no local treatment will be required; the air will be in time completely absorbed, the lung re-expand, and recovery in all probability take place unless phthisis or some other grave disease prevent it.

If effusion develop, the treatment to be adopted will depend upon the nature of the fluid, and this must be determined by the needle. In performing exploratory puncture the greatest care must be taken to avoid infection, for this is even more important, if that be possible, in the case of pneumothorax than with ordinary pleurisy. The effusions must be treated on the usual general lines, the only question to be considered being how far these general principles should be modified in the presence of pneumothorax.

1. *Where the effusion is serous.*—Serous effusions in pneumothorax may spontaneously disappear, and they frequently do if they are only in small amount. In pneumothorax, however, the conditions are not so favorable for absorption as they are with serous pleurisy, for there is no doubt that the lungs themselves play a very important part in the removal of fluid from the pleural cavity, and where they are so completely collapsed they cannot take their usual share in the process.

Where spontaneous recovery occurs the fluid may be first absorbed and air alone remain, or the air may be absorbed first and its place be taken by fluid.

Even a serous effusion should not be left too long, and I think if, after two or three weeks, the fluid still persists, it would be better drawn off by paracentesis, preferably by syphonage. On inserting the needle care must be taken that the mouth of the cannula is below the level of the fluid, otherwise nothing but air will be withdrawn and the fluid will remain behind. If the mouth of the cannula be below the level of the fluid, expiration is usually quite sufficient to fill the tube, and no suction is necessary. If, however, the syphon is not filled in this way, a syringe might be used for the purpose, or the tubes may be filled before the needle is inserted. In most cases this syphon apparatus is all that is wanted, and answers every purpose. The aspirator is a dangerous instrument to use in pneumothorax unless it be provided with a manometer to show the pressure which is being employed, and this should on no account exceed, even if it should be allowed to reach, eighteen to twenty-four inches of water. Aspirators are rarely provided with such a pressure gauge. If by using too high pressure the lung is ruptured afresh great mischief may be produced, for if (as is possible) the lung has partly re-expanded, it will become collapsed again, and thus progress be delayed; and, besides this, there is the danger that with the air some infective material may be sucked into the pleura and the effusion made purulent.

Great delicacy and caution are necessary in operating upon the pleura in a case of pneumothorax. Even in most skilful hands the aspirator may do mischief, and under ordinary

circumstances it should not be used. To employ an aspirator with the object of sucking the lung out and helping it to expand is vicious in theory and mischievous in practice.

In all cases of tapping the pleura in pneumothorax, whether for the purposes of exploration or paracentesis, especially, of course, in the latter, care should be taken to prevent the air passing along the puncture to the subcutaneous tissue. With this object, as the needle is withdrawn the finger should be firmly pressed over the puncture, and a piece of sticking-plaster, made sticky in the spirit lamp, should be quickly applied immediately over the puncture, and then a pad strapped firmly to the side so as to exercise pressure over it. Where the patient coughs much, as frequently happens after puncture of the pleura, air is likely to be driven along the puncture and to reach the subcutaneous tissue, and in this way extensive surgical emphysema may develop. With the air, especially where the effusion is purulent, it is not unlikely that infective substances will be carried with it and excite suppuration in the puncture, and even beneath the skin, and thus in the end lead to an external opening. The risk of this can be greatly diminished by firm pressure applied after the puncture in the way described.

2. *Where the effusion is purulent.*—The general principles of treatment of pus in the pleura will of course apply. The only question is how far they may require to be modified in the presence of pneumothorax. As in the case of empyema, three courses only are open—it may be left alone, it may be tapped, or incised.

(a) *If left alone.*—Although in empyema cases occur in which the pus is spontaneously absorbed, and thus cure effected, I do not know any instance of the kind in pneumothorax. If pyopneumothorax be left alone the pus will ultimately make its way out, either through the lungs or externally. If through the lung, spontaneous cure is extremely unlikely, though it may perhaps occur, as in one of the cases which I have reported. If discharge takes place externally the wound will probably have to be extended, and the result will be the same as if an incision had been deliberately made, but with this disadvantage, that a greater length of time will have elapsed, and the lung, therefore, be in a less favorable condition for expansion.

As a rule, with pyopneumothorax a condition of well-marked hectic develops, and if nothing is done the patient dies ere long exhausted, and that, too, even if the pus make its way out internally or externally. It follows, therefore, that to leave a case of pyopneumothorax alone gives the patient but little chance of recovery.

(b) *Paracentesis.*—Temporary relief can, of course, be given by tapping, but I do not know of any case of pyopneumothorax in which paracentesis has led to recovery. The operation is certainly not devoid of risk, for the pus is, as a rule, too thick to be removed by syphonage. Suction, therefore, has to be used, and there is considerable risk that in sucking the pus out the lung will be ruptured afresh, and

thus much mischief be done. Besides this, the coughing which follows the operation often forces air, and with it some pus, along the track of the needle. Thus suppuration and sometimes a considerable subcutaneous abscess forms, which has to be freely incised, and in this way an indirect communication with the chest is made; or the suppuration may take place beneath the periosteum, and in this a considerable portion of one or two ribs necrose.

In one case of this kind nearly six inches of the sixth rib necrosed, and had to be removed in two successive operations. Although there was not at first a direct communication with the pleura, the abscess ultimately burst in both directions, so that when the rib was removed a very large opening into the chest was left.

If paracentesis be performed, it must be remembered that the object is to remove the pus and not the air, and therefore the mouth of the cannula must be directed to the lower part of the chest, where the pus lies, otherwise air only will escape and no pus be obtained. Also care must be taken after paracentesis that pads should be applied and firm pressure made over the puncture, to obviate as far as possible the objections mentioned, and in order to keep the puncture as small as possible only a small or medium-sized cannula should be selected.

(c) *Incision*.—From what has preceded it would seem that the only thing to be done for pyopneumothorax is to treat it like an empyema and incise early, and that is the conclusion which I think ought to be drawn. At the same time most authors express an opinion adverse to an incision in pyopneumothorax.

The published statistics of pyopneumothorax are very much more unfavorable than those of empyema. For this there must be some good reason. It may be that (1) the disease is more serious in itself, (2) that the lung is more likely to be gravely involved, or (3) lastly, that the methods of treatment differ.

As regards the gravity of the affection itself, one cannot compare all cases of pyopneumothorax with all cases of empyema, for the great majority of cases of pneumothorax have their origin in phthisis, while the majority of the cases of empyema do not; and we know that empyema occurring in the course of phthisis and due to it is of very much graver prognosis than when it is due to other causes. That the presence of air in the pleura has really nothing to do with the results is shown by the fact that in tapping empyemata air may escape into the pleura, or even the lung itself be ruptured; yet this air is in the majority of cases soon absorbed, and the case runs its ordinary course. It may be thought that the perforation in the lung, being as a rule from a tubercular cavity, will not itself heal and thus the conditions will be much more unfavorable than in empyema. Yet this is not altogether correct, for in many cases the perforation does heal even in a tubercular cavity, while in some of the cases of pyopneumothorax in which post mortem

the hole is found patent, the hole found may be not the original perforation, but one which the pus has subsequently made for itself in finding its way out through the lung.

Putting aside, then, the fact that the lung is more likely to be diseased in pyopneumothorax than it is in empyema, there seems no other reason why the air and pus in the pleura should not be treated in the same way in the two cases, so that the more unfavorable results in pyopneumothorax must, in part at any rate, be attributed to the difference in treatment of the two affections. The difference in the statistics of pyopneumothorax and of empyema would not be so great if we compared pyopneumothorax not with empyemata operated on early, but with those which were neglected, *i. e.* not operated on at all or only after long delay. The statistics of pneumothorax are drawn from old sources, and there are no recent statistics of pneumothorax treated by early incision, and I venture to think that if there were the results would be very different.

The reasons given for the postponement of incision or even of paracentesis by older writers are chiefly two:—first, that by the compression which the pneumothorax exercises upon the lung on the affected side the progress of tubercle in it is checked; and secondly, that the tubercular mischief often makes rapid mischief when the lung re-expands.

These *a priori* objections are not absolutely correct, and at the most express only a part of the truth; and against them must be set the facts that tubercle *may* certainly progress in a collapsed lung, for recent tubercles may be found in lungs which have been long collapsed, and that tuberculosis does not by any means always rapidly progress in an expanded lung after its having been collapsed, as is shown in the case of serous pleuritis and in empyemata; while, on the other hand, tuberculosis may develop and progress rapidly in the opposite lung after, and apparently in consequence of, the collapse of the lung on the affected side.

The same arguments were once urged against the tapping of serous effusions which were thought to be tubercular, as well as against incision in empyema, and with as little reason. They were overruled by experience. It follows, therefore, that these *a priori* objections should not be allowed to weigh much against the treatment of pyopneumothorax by incision.

At the present time pneumothorax is very rarely deliberately incised. If an incision is made, it is generally either because the pus has spontaneously discharged itself externally, and the wound requires extension, or because after paracentesis the puncture has suppurated.

My own feeling is strongly in favour of the treatment of pyopneumothorax by incision. We have no statistics as yet which can guide us in the matter, and we must make them for ourselves, but I believe it is quite justifiable to make a forward step in this direction.

In a case of pneumothorax, as soon as the effusion which

has formed is known to be purulent, the question of its removal should be considered. As long as it is merely sero-purulent, and especially if it will flow through a syphon tube, the effect of paracentesis may be tried. If, however, the pus be thick and viscid, and requires an aspirator with more or less suction, the question of incision should be raised. There need be no great hurry in deciding, for it is well to give the perforation in the lung time to close and heal firmly. At the same time it would be wrong to postpone incision too long. There will be room, no doubt, for considerable judgment to be exercised in the choice of the exact time for operation, which would have to be determined partly by the length of time which had elapsed since the pneumothorax, as well as by the general condition of the patient and the state of the lungs.

The operation should be conducted in the usual way, and there is but one question which remains for consideration, viz. the propriety of washing the side out. In many of these cases which are tubercular the pus is not only thick, but seems to contain a large amount of mucus, and is very viscid. I think it well to wash out the pleura freely at the time of operation, and to repeat it from time to time if it seems necessary. I have done this in several cases, the result has always been satisfactory, and I have never seen any harm come from it.

In many cases pyopneumothorax has come under my treatment only after some time had elapsed from the commencement, and I therefore had but little opportunity of trying what I am here advocating, viz. early incision; but I believe that not only is it the right line of practice, but that it will soon come to be recognised as such, and become the rule of practice. If a pneumothorax is left for months there is the same prospect, neither more nor less, of curing it by incision as in a case of empyema left untreated for as long a time, and therefore, if incision is to be made in a case of pyopneumothorax, it should not be postponed too long.

I gave an account recently of a case (*Brit. Med. Journ.*, November 27th, 1897) of pyopneumothorax of several months' duration, in which incision, late as it was, resulted in recovery. The patient was a man *æt.* 34. He came under my care five months after the onset of pneumothorax, and was found to have a foetid purulent effusion. The side was then incised, but it was not found necessary to excise a piece of rib. The lung rapidly expanded, and on the day following the operation was in contact with the chest walls in great part. The cavity was washed out, and the discharge rapidly lost its foetor. The patient was practically well, except for the track in which the drainage-tube lay, within a week from the operation. He gained flesh and strength rapidly. The sinus was difficult to close, and chiefly on account of the interest of the case the patient was kept in hospital. By October the tube was out and the patient well. He has been at work for several months, and looks and feels perfectly well. Just lately a

little pus has been discharged from the front of the old incision six months after the sinus had closed; but there is nothing in the condition of the patient, nor in the physical signs, to point to anything more than a small collection of pus in the track of the old sinus. A fine and short tube has been inserted again; the discharge is but little, and no doubt soon this sinus will close again.

Some Rectal Diseases.

By F. C. WALLIS, M.B., F.R.C.S., Assistant Surgeon to Charing Cross and St. Mark's Hospitals.

II. HÆMORRHOIDS.

HÆMORRHOIDS are so common, that from a medical point of view they are too often treated with the contempt which we are told is bred of undue familiarity. The consequence is that a large amount of discomfort, pain, and even misery is unnecessarily borne by those suffering from this complaint, who regard an attack of piles on much the same lines as a cold in the head, and it is allowed to "run its course."

Even when advice is sought, the treatment ordered is too often of a most perfunctory character, and more often than not a rectal examination is conspicuous by its absence. That this should be the case is indeed a pity, for when taken in hand early a great deal can be done in the way of palliative treatment, and if operative measures are necessary the sooner they are undertaken the better.

The causes of hæmorrhoids have grown in number to quite a long list, but before considering these it will be as well to briefly discuss a few anatomical facts with regard to the rectum and anus.

The rectum is supplied by the superior hæmorrhoidal artery, and both the gut and the vessel develop together; the method of entrance of the vessel to the submucous tissue and its distribution are facts well known, and easily read about in any anatomical book, and it will be remembered that the vessels run *between* the muscular and mucous coats, and end *just about* the internal sphincter.

The venous return commences over the internal sphincter by a series of pouch-like dilatations, forming what is known as the hæmorrhoidal plexus; this gradually forms into the returning veins, which are without valves, and these ultimately empty into the portal system through the inferior mesenteric veins.

The middle hæmorrhoidal supplies the periproctal tissues. The inferior hæmorrhoidal is distributed to the anus; the venous return from these vessels opens into the systemic circulation by means of the internal iliac veins.

There is *not free anastomosis* between these vessels, as

has been so frequently taught. This can be easily proved by injecting the various vessels with different coloured glycerines. To further emphasise this point let us briefly consider some points in the development of this part of the body.

The gut (with the superior mesenteric artery) comes down to the anal region, and ends as a cul-de-sac. The proctodeum (with the two other arteries) ultimately opens into the gut. This opening is generally at the anterior surface of the bowel, and a pouch (post-anal) remains posteriorly which gradually becomes obliterated. In the case of an imperforate anus the circulation of these two parts is quite distinct, and when the fusion is effected there is very little alteration in this arrangement. Bearing these facts in mind it will be quite obvious that hæmorrhoids must necessarily depend on different causes according to their situation.

Hæmorrhoids have been divided into external and internal varieties, and a third kind has been described as interno-external—a bad term, but still descriptive of the variety. I propose to discuss the first two separately, and then to say a few words about the third form.

External hæmorrhoids are due initially to a varicose condition of the anal veins, but they do not as a rule give rise to any symptoms until from some cause or another they become inflamed, when they usually become thrombotic. The erect position, constipation, and straining, are causes producing varicosity, especially the two latter.

When a thrombus is formed, the veins and surrounding tissues become hard, tense, and painful; the pain is of a throbbing character, and the patient is unable to stand or sit with any comfort. Unless relieved, this pain continues for many days, and ends in suppuration, or the pile may become inflamed and superficially ulcerated. If neither of these contingencies occurs, the clot is gradually absorbed, the infiltrated tissues subside, and a tag is left which, as a rule, causes no further discomfort.

A certain amount of relief may be obtained by hot baths and fomentations in cases of thrombosis—but the only real relief, and the proper treatment, is to incise the vein over the thrombus, and turn out the clot or clots. Both before and after the parts are washed in 1—2000 perchloride, and some cotton wool soaked in the solution is placed on the opened vein and kept in place by a pad and T-bandage. Everything will be healed, and all swelling have subsided, in a few days. If suppuration has occurred, a free vent must be given to the pus, and fomentations applied. In the case of an inflamed and ulcerated condition the part should be fomented until the inflammation has subsided, and then the pile should be removed.

A certain number of patients suffering from this malady will not permit any "cutting operation," and from one circumstance or another cannot foment the parts. For such as these the local application of belladonna and glycerine with a little opium added is beneficial.

Another useful application is the following:

R Bismuth Subnitrat.	...	...	5ij
Cocain. Hydrochlor.	...	...	gr. iv
Vel			
Eucaïn. Hydrochlor.	...	...
Pulv. Calomelan.	...	...	gr. x
Lanolin	...	...	ad 5j

Ft. Ung.

Patients who have had one attack of external piles should be warned not to sit on cold or damp places, especially after taking exercise. Stimulants should be taken with great discretion, and malt liquors should be forbidden. The bowels should not be allowed to become constipated, and local washing with cold water and soap after the bowels have acted should be made a strong point. It seems to me waste of time to give a lot of directions how to avoid piles. Complaints of this nature are only interesting, among the laity, to those who suffer from them.

It is a common belief that newspaper has some special pile-producing product of its own. I cannot find that there is any ground for it, as far as the composition of printer's ink is concerned. The paper is usually harsh, and may wound the muco-cutaneous surface, and thus expose the wounded spot to the possibility of infection from the bowel excretion. Beyond this, I think, there is no reason for this old-fashioned superstition.

Excision of external piles.—It is rarely necessary to do any extensive operation for external hæmorrhoids, nor indeed is it advisable. Operations for these, if injudiciously carried out, are apt to lead to bad anal strictures. Unless the hæmorrhoids are more or less pedunculated, I make it a rule *not* to ligature the hæmorrhoids, but to cut as much as is necessary away with pile scissors, and then to pick up any bleeding points and tie them separately. By this means the minimum of contraction is obtained, and the tendency to any stricture done away with.

Internal hæmorrhoids.—The initial cause of internal hæmorrhoids is, I have no doubt, an anatomical one. This is apparently still a matter of dispute, into which I cannot enter here, but I will briefly state what I believe to be the facts.

1. The rectum has a powerful arterial supply.
2. The veins commence in a series of small pouches.
3. They have no valves.
4. The tissues in which they lie are little or no support to them.
5. The blood returns through the portal system, which is a sluggish stream comparatively, and hepatic congestions render the return often still more slow.

Bearing these facts in mind, it is easy to understand that *mechanical* causes, as constipation, constant straining, long standing, or sedentary occupations, the pressure of tumours, such as a pregnant or misplaced uterus, or a stone in the bladder, may produce the condition of hæmorrhoids.

Again, excesses of eating and drinking and constant purgation are common exciting causes of hæmorrhoids.

Three *varieties* of hæmorrhoids are usually described.

1. The columnar or arterial.
2. The pyramidal or venous.
3. The nævoid or capillary.

I have placed them in the order of what I believe to be their frequency.

The *columnar* consist of the hypertrophied longitudinal folds of mucous membrane (pillars of Glisson). The swellings commence between the sphincters, and the folds can be traced some way up the rectum. They contain branches of the superior hæmorrhoidal artery, which are sometimes of quite a large size.

The *pyramidal* variety are felt inside the sphincter as soft globose swellings, which disappear under pressure, to return immediately the pressure is discontinued. They consist mainly of veins covered by thinned mucous membrane. The hæmorrhage from this variety is not so frequent as in the other two, but the amount lost at a time is often rather alarming, owing to the perforation of a vein.

The *nævoid* variety, when existing alone, is often almost impossible to detect with the finger; but when seen by means of a speculum, the bright red, slightly elevated swelling, which bleeds readily, cannot be mistaken.

The main symptom of internal hæmorrhoids is loss of blood, which although usually only slight each time, soon blanches the patient, producing often a state of quite advanced anæmia. This condition of anæmia occurs more frequently in young women, who do not pay the same attention to small blood losses that male patients do.

Mucous discharge is generally present to a greater or less extent. *Pain* is *not* often complained of, unless, as occurs at times, there is some ulceration of or between the hæmorrhoids. When the hæmorrhoids are prolapsed and strangulated, or inflamed, the amount of suffering may be very great.

Patients who are run down from loss of blood, which may have been going on for many years, are apt to complain of various pains in the loins, back, head, and other parts of the body.

The complications which may exist with hæmorrhoids have given rise to a great deal of discussion, and a corresponding variety of opinions have been given, which cannot be discussed in this paper.

Prolapse is of frequent occurrence, and happens, as a rule, only in hæmorrhoids of some standing. The patients are usually able to return them after the bowels have acted, and at first they remain in the bowel until the next evacuation. Later on they come down when the patient walks about or does any active work, and are a constant distress.

Prolapsed piles may become strangulated and gangrene may supervene, owing to the action of the sphincter.

Acute inflammation of a septic variety may also happen when prolapse occurs. The treatment in these cases is to return the hæmorrhoids under an anæsthetic, and then apply fomentations, the sphincter being well stretched at the time, or if necessary divided.

If the piles are only strangulated and not gangrenous or acutely inflamed, they may be removed at once; at least, this is the practice with which I agree, although others do not.

Uterine disorders are common complications, and often primary factors of hæmorrhoids in women. These should be treated first, before any operation is done for the hæmorrhoids.

Hepatic troubles are also commonly associated with hæmorrhoids, and great caution should be used as to the choice of cases. An operation may be the reverse of beneficial.

Hæmorrhoids may be complicated with fissure, fistula, or small polypi; the latter are by no means infrequent, and act as a source of irritation to the bowel.

When operating on hæmorrhoids and a fistula, if the fistula is cut through first, care must be taken if the piles are ligatured not to take up too much mucous membrane, otherwise complete temporary occlusion of the lumen of the bowel may occur, and possibly some permanent stricture.

The *treatment* of internal hæmorrhoids is either palliative or radical.

The *palliative measures* are both constitutional and local. Constitutionally, diet is the main thing to pay attention to. Every one eats too much (if they are able to do so), and the commonest cause of hæmorrhoids is excessive eating; but it is a most difficult thing to get a patient to act in moderation in this respect, or even with a certain amount of judgment.

The same remarks apply to alcohol, more especially to all forms of malt liquor, which are the worst things possible for people suffering from the malady under discussion.

If necessary, one of the multitude of well-known laxatives should be taken from time to time, but drastic purgatives are to be avoided.

When there is much hæmorrhage, or indeed in all cases where the patient complains mainly of loss of blood, I can strongly recommend the internal administration of the tincture of hamamelis in ten-minim doses, three or four times a day. This, combined with the local application of hazelin ointment, has been found to be of the greatest benefit. Subchloride of mercury ointment is another very favourite local application at St. Mark's Hospital. These ointments should be applied at night-time, and both before and after the bowels act. But after an evacuation it is *most important* that the parts should be thoroughly washed with cold water, more particularly if the piles prolapse to any extent. If the above treatment is carried out, much relief will be obtained in a number of cases.

Another form of palliative treatment which is useful is the injection of each pile with about five minims of a 10 per cent. solution of carbolic acid. In prolapsed *reducible* piles it acts well.

The pain caused by the injection is slight and transient, and sometimes one injection is sufficient. In a few days the piles shrink up and hardly prolapse at all, and the relief to the patient is marked. It must not be considered a "cure;" it is only a palliative measure, but the effect may last for some years. I have had patients come to me who say that they want the process repeated, as they have had relief for three, four, even five years, after one or two injections.

This method of treatment has been strongly denounced by one or two American surgeons, and Allingham does not regard it favourably.

My own experience is stated above, and my colleague, Mr. Swinford Edwards, has used it some scores of times with advantage to the patient, and in no instance has there been any harm done. Unless some extraordinary recklessness is associated with this simple treatment, I cannot imagine that such shocking results as have been recorded are possible.

Operative Measures.

It is not proposed to discuss methods which are practically not done now, for the removal of hæmorrhoids.

The methods of operation now carried out are—1. Clamp or cautery operation. 2. Crushing operation. 3. Whitehead's operation. 4. Ligature.

Three main considerations must be borne in mind when advocating any operation:—(a) The immediate safety. (b) The ultimate result. (c) The comfort of the patient.

It will, perhaps, be best to briefly describe these operations, and then to see how far they fulfil these considerations.

In the clamp and cautery operation, each pile is clamped at its base and then removed by scissors, the cut margin being scarred by a cautery at a dull red heat. This operation is said to be less painful than ligature, and this was its main recommendation; but the amount of destruction of tissue, ultimate possible stricture, and great risk of secondary hæmorrhage more than counterbalance the avowed painlessness, which is not always borne out in actual practice.

The crushing operation, as carried out according to Allingham's method, and with the instrument which bears his name, is in certain picked cases a good method. The main recommendation here is the small amount of pain experienced after the operation in the majority of cases. It would, however, be unwise to definitely state beforehand that no pain would be felt after the operation.

In this operation the sphincters are gradually but thoroughly dilated, and the pile is pulled through the clamp, which is screwed up slowly as tightly as possible;

the clamp is left on about a minute, the pile is cut off, and then the clamp is slowly unscrewed and the tissues are released. Care must be taken not to take up too much tissue with the clamp, lest undue contraction results later.

Mr. Alfred Willett has used this method for some years past, and in his hands it has been most successful.

Whitehead's operation is, so to speak, "a thing of itself," and although fascinating from a surgeon's point of view, it cannot be recommended for general use, and even skilled surgeons will find only a small percentage of cases where the operation is really justifiable.

This operation is done with the patient in the lithotomy position. The mucous membrane is separated all round the anal orifice from the skin, and then dissected off the sphincters. The mucous membrane with the hæmorrhoids is next brought down outside the anus, the pile area is now removed, and after stopping the hæmorrhage, which may be quite free, the cut end of the mucous membrane is sewn to the cut skin margin. Primary union is supposed to occur, and the patient is well in a fortnight.

All this sounds easy and delightful, but it certainly is *not* easy and may be far from delightful, if undertaken by anyone not thoroughly practised in operating. The external and even the internal sphincters may not be recognised; the skin may be removed round the anus by mistake. The hæmorrhage, as I have said, may be quite free. Primary union will not occur in most cases, and many unpleasant sequelæ may happen when once suppuration takes place.

This seems a severe criticism for what is really a clever piece of surgery, which in certain cases, under proper conditions, may have the happiest result. My object is to impress on the young and ardent surgeon that this operation is not one to be lightly undertaken for a disease which can be as well, if not better treated by a much safer and more simple method.

The operation by ligature is now well recognised to be by far the best and safest way of dealing with piles.

During the last eighteen years, 4643 patients have been admitted into St. Mark's Hospital for operation. Of these, 1197 were operated on for hæmorrhoids (635 males and 562 females), nearly 26 per cent. of the whole number.

Of these 1197 patients only four have died, and the causes of death are as follows:

1. W. S—, æt. 49, admitted June 26th, died July 29th, 1882. Cause of death: Peritonitis.
2. R. T. D—, æt. 63, admitted April 3rd, died April 9th, 1886. Cause of death: Phlegmonous cellulitis after operation; chronic nephritis.
3. M. K—, æt. 56, admitted June 24th, died July 28th, 1887. Cause of death: Chronic bronchitis; renal disease.
4. J. S—, æt. 71, admitted March 8th, died March 13th, 1890. Cause of death: Syncope; subcutaneous extravasation of blood; sarcoma of sacrum.

Taking the whole four, the death-rate is '33 per cent.,

which is small enough, but it must be admitted that three out of the four cases above were obviously not patients upon whom an operation should have been performed, and this leaves one case in 1197 which can be really attributed to the operation !

The points to be remembered about the operation are—

1. The sphincters should be gradually but fully dilated.
2. The pile should be pulled down by a hook and cut in the longitudinal axis through the lower sulcus, leaving the vessels and mucous membrane above untouched.
3. The ligature should be of stout silk which has been well boiled, and kept in either perchloride or carbolic, and when applied must be tied quite *tight*; and as a matter of practice a third knot should be tied.

These are the main points to be remembered.

It is a common practice at the end of the operation to introduce either a plug of dry wool or else a strip of gauze into the rectum. I do not believe this proceeding is of any use, and I am quite sure that it often causes pain.

The after treatment, complications, and sequelæ of hæmorrhoids will be discussed in the next paper.

Aboriginal Medicine among the Mundas of Chota-Nagpore.

By Surgeon-Captain F. P. MAYNARD, M.B., D.P.H., Indian Medical Service, General Hospital, Calcutta.

ABOUT fifteen months ago, in contributing a short account to this JOURNAL of experiences met with as Medical Officer of the Baluch-Afghan Boundary Commission, I mentioned some curious forms of medical treatment met with among the Baluchis and Afghans. Since returning from that mission I have been Civil Surgeon of Lohardaga in Chota-Nagpore, where nearly 400,000 out of a population of about a million and a quarter belong to the aboriginal tribes classed under the term Kol. They are principally Mundas and Oraons, and while studying the language of the former I came across some medical facts which may be of interest to the readers of the JOURNAL. The Mundas are a Kolarian tribe; their language is purely colloquial and very difficult. No abstract ideas can be properly expressed in it, and Hindi is so rapidly invading it that even now it is rare, except in certain parts of the district, to meet with a man who speaks it in its pure form. All the same their anatomical terms are fairly numerous. They have separate names for the different parts of the extremities, *i. e.* for the fingers, arm, hand, hip, thigh, knee, leg, &c.; also for some of the internal organs, and for the features of the face. The lungs, kidneys, and liver are named, but the word for heart means "head of the liver," in which they think life resides; the brain is also known.

The word for uterus means a paddy nest or receptacle for rice. The word for tongue is the same as in Chinese, which language is regarded by some philologists as akin to Mundari.

Some of the Mundas have remarkably well-marked Mongolian features—slanting almond eyes, and even fair skins, though as a race they are the blackest on earth, except, perhaps, negroes. They believe that there is one passage in the neck for both air and food, and that the breath goes straight down into the stomach. They know the temple, and that a blow on it is likely to prove suddenly fatal; they also recognise the temporal pulse, for which they have a special word. The compound word used for ribs means the "sound-bones." The precision of their anatomical terms may in part be due to their burial customs. They bury their dead temporarily, then after some months dig up the bones and re-bury them with ceremony in their burial grounds; in this way obtaining a knowledge of the bony skeleton not possessed by ordinary mortals. The Mundas' terms for disease are very limited, and death in their opinion is due generally to fever or diarrhœa, or swollen body (dropsy). One word, "hasu," means wound, pain, bruise, and disease in general. It is tacked on to the name of any part, and implies disease of that part—of what nature doesn't matter or appear to interest them. Swelling is used for abscesses, tumour or swelling of any kind, and for dropsy. Cholera and diarrhœa are the same, though they recognise suppression of urine. Dysentery is unnamed, though common enough. Names for venereal diseases are borrowed from Hindi when required. Hæmaturia is named, though stone is rare. Intestinal worms are frequent and honoured with names. A fatal form of illness occurring in childbed is recognised and named; it is called "the cold illness," and is described as a fever accompanied by dry cough and swelling of the feet. Like some other races in India they believe that women dying during pregnancy or in childbed become ghosts with inverted feet (heels foremost), having thorns in their soles, and fire issuing from their mouths, and in this state haunt the neighbourhood of their villages. They are great on skin diseases, perhaps because they never wash, and they distinguish between various shapes and sizes of pimples and kinds of boils. One remarkable fact is that the Mundas have a compound word meaning "to cut young ones out of the womb of the mother." I never heard of its being done, however. Post-mortem rigidity has its own term. As a recognition of the ætiology of disease is rather rare among natives of India, it is an interesting fact that they have a special word to denote that a disease is infectious. The following diseases were declared to me to be infectious, meaning thereby, it was explained, capable of spreading from the individual infected to the healthy people around:—ophthalmia, cholera, hemicrania, smallpox, syphilis, itch, "some fevers," epilepsy (by means of the breath), leprosy, and gonorrhœa. The two words

they use for the menses are descriptive of the two periods when they say menstruation occurs, viz. at full moon, and at the period of dark nights midway between the two full moons.

Their medicines are few, mainly for applying to wounds, curing itch, producing constipation, and purgatives. Of a root used as a purgative a piece (crushed in water) "as long as four fingers' breadth" will (they say) cause four stools "as long as two fingers' breadth," two stools, and so on. Of surgery they know nothing apparently, and their reaction to, and behaviour after, operations is well illustrated by a man on whom I operated for a fairly large liver abscess (very rare, he it known, among them, and due in this case to alcohol). Three or four days after operation he left the hospital, as he said he felt all right, and he was seen wandering about with a large drainage-tube sticking out of his epigastrium, and no dressing on. He recovered.

With reference to the discussions that have taken place of late regarding the order of development of the different senses and faculties in man, the question of colour vision in the Mundas is a very interesting one. The only words connected with colour they possess are black, white, and red. I cannot do better than quote the following extract (by permission) from the manuscript of a grammar of the Mundari language shortly to be published by Father Hoffmann, S.J., whose knowledge of the people and their language is very intimate.

"What seems more surprising still is the fact that they have comparatively few words denoting such purely physical qualities as must needs strike them. Thus they have only three names for colours: the pure blue sky of Chota-Nagpore, the light green rice-fields, the rich forests with their numberless hues, as well as everything else that is not white or red, is simply called *hende*—black. From light grey to the purest white everything is *pundi*—white. Whatever colour does not fall under these two heads is *ara*—red. And yet the Munda is by no means colour-blind or indifferent to colours; he delights in them. If you urge him to specify some kind of red, he will tell you that it is red like saffron, or like this or that flower; again, to specify some particular kind of his wide range of blackness, he will tell you that something is black like the rice-fields, or black like the leaves of this or that kind of tree, or like the sky, or like the night, or like sleep. On the other hand, he has a set of words denoting colour, but they are restricted to his cattle and his fowls. Again, though the Mundas are probably the darkest race in India, they distinguish between the *esel*, or fair, and the *hende*, or black individuals of their tribe. For the new-comer from Europe it takes some time before he perceives the difference."

A profusion of bright colours is especially relished. They denote it by a jingle word which savours of the nervous excitement it causes in them—*chiribiri-chiribiri*.

Witchcraft flourishes among them, and nearly every village

is cursed with its *soka*, or witch-diviner, who, needless to say, makes a good thing out of it. He is in particular request during famine and pestilence, and many are the assaults and even murders brought about by his agency. Human sacrifice was common among the Kols until recent years. They will sacrifice almost anything, indeed, to please the evil spirits who cause disease, failure of the rains, and other calamities. They have only one good spirit—the sun-god; to whom, being good, they of course consider it unnecessary to offer any sacrifices. Evil spirits swarm in every village and grove, and have to be appeased at all costs.

A Case of Thrombosis of the Femoral Artery following Pneumonia.

By JOHN J. BLAGDEN, M.R.C.S., L.R.C.P., Harwood, Horrabridge, South Devon.



RS. D—, æt. 92, complaining of severe attacks of shivering, headache, and slight cough.

The previous history was that she had never been laid up for a day since her last confinement—about fifty years previously.

On the morning of December 9th, 1897, she was in her usual health, and had walked half a mile to fetch milk from a farm. On her return about 11.30 she had a violent rigor and went to bed, where I found her at 1.45 trying in vain to keep warm. She was in full possession of her faculties, but anxious and distressed. Pulse 110, soft and somewhat intermittent. Temp. 102.5°; skin feeling harsh and dry, *alæ nasi* working. Examination of the chest revealed nothing abnormal beyond a slight accentuation of the second sound at the pulmonary base. I considered it to be either pneumonia or influenza—the latter being epidemic at the time,—and ordered her stimulants, milk diet, and a mixture containing Liq. Ammon. Acetat., &c.

December 10th.—Temperature unaltered; pulse extremely rapid, feeble, and intermittent; she complained of pain in her left side, and was coughing up reddened viscid sputum. Examination of the chest revealed dulness, crepitations, and bronchial breathing over the lower lobe of the left lung. Considering her age I gave a very grave prognosis, and considered that her best chance lay in regulating and stimulating the action of the heart; so I increased her stimulants, and gave her doses of Liq. Strych. *mv*, Tr. Digitalis *mx*, *sextis horis*. This produced a decided effect, her pulse being greatly improved that evening, and next morning being about 100, and intermittent about one beat in twenty.

On the 11th and 12th she remained in about the same condition, her temperature varying between 101.5° and 103°; but when I visited her on the evening of the 12th I found her far more comfortable, her temperature being then 99°.

On the 13th her temperature was 97.8° in the morning, and she thought herself, and seemed, on the high road to recovery.

On the 14th (the sixth day of the disease) at 1.30 a.m. I was called to her in haste, and found her almost speechless from pain in the left popliteal space, with great tenderness over the entire course of the femoral artery, in which no pulsations could be felt; the foot and leg were quite cold. I wrapped the limb in a blanket, and surrounded it with hot-water bottles, and was obliged to give her morphia gr. 4 hypodermically to relieve her intense pain.

From this time onwards she became gradually comatose, only complaining of pain, and refusing nourishment. A huge acute bed sore formed over the left buttock. She was seen in consultation with me by Dr. T. E. Smyth, of Tavistock, who agreed that for many and obvious reasons operative measures were out of the question, and that I should do my best to relieve her pain by morphia.

On the 19th the first indications of a line of demarcation appeared at the level of Poupart's ligament, and on the 20th, the twelfth day from the onset of pneumonia, she died.

I consider it a case of thrombosis of the femoral artery following pneumonia, and think it probable that one or more branches of the internal iliac were also blocked, thus accounting for the bedsores. Such cases are, I believe, of extreme rarity, which is my excuse for publishing notes of this case.

It seems also worthy of note that a person of her great age should have survived the direct attack of pneumonia. In two other similar cases that have come under my care the patients, aged 90 and 100 years respectively, have died of heart failure due to hyperpyrexia in an early stage of the disease.

Notes.

THE polling for an Assistant Surgeon, *vice* Mr. Walsham, who has become full Surgeon, took place on Thursday, April 28th. The result was announced about a quarter-past three o'clock, the figures being—

Mr. D'Arcy Power	...	...	...	71
Mr. Berry	...	...	...	60

* * *

MR. D'ARCY POWER entered the Hospital in 1878, having previously obtained a First Class in the Honours School of Natural Science at Oxford. He was successively Assistant Demonstrator of Physiology, Ophthalmic House Surgeon, House Surgeon, Curator of the Museum, and Demonstrator of Practical and Operative Surgery. He is also Surgeon to the Victoria Hospital for Children at Chelsea, and last year held the Hunterian Professorship in Surgery and Pathology.

* * *

ONCE again the Jacksonian Prize has fallen to a Bart.'s man. This year it has been awarded to Mr. Percy Furnivall for his essay on "The Pathology, Diagnosis, and Treatment of the various Neoplasms met with in the stomach, small intestine, cæcum, and colon." We offer him our heartiest congratulations on having kept up the splendid record secured in the previous three years by Mr. Waring, Professor Kanthack, and Mr. Bailey. We also beg to congratulate him on other grounds. If any of our readers are ignorant of those grounds they are referred to p. 128.

* * *

MR. BOWLBY'S wedding on Tuesday, April 12th, at Buckworth, was accompanied by much ceremony and rejoicing. In the evening the Hon. H. W. and Mrs. Mostyn entertained the villagers to a supper, followed by a dance.

Letters referring to some wedding presents from members of the Hospital to Mr. Bowlby will be found in our correspondence column.

* * *

THE Annual Dinner of the Amalgamated Clubs will be held on Saturday, June 11th, after the cricket match *Past v. Present*. The place of meeting will be the Holborn Restaurant, and Dr. Griffith will take the Chair. It is hoped that all will make an effort to be present.

* * *

DR. OSWALD BROWNE, Dr. F. P. Weber, and Dr. J. H. Campbell have been elected Fellows of the Royal College of Physicians of London.

SURGEON-CAPTAIN H. F. WHITCHURCH, V.C., in medical charge of the 24th Bengal Infantry, has again been mentioned in despatches; this time for the readiness of his arrangements on the North-west Frontier Campaign in India. It is added that he was in the firing line attending to the wounded from the time the action began.

* * *

SURGEON-MAJOR RONALD ROSS, I.M.S., has been placed on special duty, and is now working in Professor D. D. Cunningham's laboratory in Calcutta at the mosquito theory of the malaria parasite. It will be remembered that Dr. Ross has already distinguished himself by his original researches on this subject.

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SURGEON-CAPTAIN F. P. MAYNARD, I.M.S., Officiating Second Resident Surgeon, Presidency General Hospital, Calcutta, has taken over the duties of editor of the *Indian Medical Gazette*.

* * *

OUR account of the presentation of a picture and testimonial to Mr. Berry was much appreciated in various quarters. Indeed, so much did one of our contemporaries appreciate it that nearly a column was quoted in its pages without the slightest acknowledgment.

* * *

THE Brackenbury Surgical Scholarship has been awarded to H. Mundy.

* * *

THE Wix Prize for the best essay on "The Life and Work of Sir Charles Bell" has been awarded to W. E. L. Davies.

* * *

R. A. YELD has taken the degrees of M.B., B.C., at Cambridge.

* * *

E. C. BRIDGES has taken the M.D. degree of Durham.

* * *

THE degrees of M.B., B.S., have been conferred at Durham upon H. E. M. Baylis, F. W. Crossman, R. C. J. Stevens, P. E. Turner, and M. D. Wood; and that of M.B. upon H. J. Godwin.

* * *

WE are requested to call attention to the fact that the Matrons' Council, a society composed of the matrons of hospitals, proposes to hold its first annual conference in London on June 15th and 16th next, when papers on questions of professional and public interest will be read. Such subjects as "The Matron's Duty to her Profession," "Specialism in Nursing," and "A Practical Standard of Nursing" will naturally appeal to trained nurses; and the subjects of "Home Hospitals," "Nursing as a Domestic Art," "Suggested Reforms in the Army Nursing Service," and "Women's Work on Infirmary Boards" will appeal to all those members of the general public who are alive to the importance of the efficient nursing of all classes in the hospital and the home. The Matron of St. Bartholomew's Hospital will take the chair at this conference.

Amalgamated Clubs.

CRICKET CLUB.

The following are the officers for the coming season:

Captain.—E. F. Rose.

Secretaries of 1st XI.—J. C. Sale, H. W. Pank.

Captain of 2nd XI.—H. J. Pickering.

Vice-Captain and Secretary of 2nd XI.—A. H. Bostock.

Committee.—H. Bond, F. H. Maturin, J. W. Nunn, H. S. Greaves, J. A. Willett, W. H. Randolph.

A very strong match card has been arranged for this season,—in fact, quite the strongest we have ever had. The weaker of our last year's fixtures have been dropped, and matches arranged with Oxford University Authentics, the Wanderers, and Esher.

All but two of our last year's team will be again available, and in addition there are several freshmen who come up with good reputations. If all will only do their best to play regularly we ought to have an excellent chance of regaining the Cup that we lost last year. The pitch at Winchmore Hill was relaid at the beginning of the winter, and also a piece for practice wickets. The exceptionally mild winter has allowed the turf to get well settled, and there seems every prospect of excellent wickets for the coming season. The Past v. Present match has been arranged for Saturday, June 11th. All old Bart.'s men willing to play for the Past are requested to write to the secretary as early as possible. It is to be hoped that a more representative team will be got together than was the case last year.

The 1st XI matches arranged are—

Date.	Opponents.	Place.
Wed. May 4	Practice game	Winchmore Hill
Sat. " 7	R.I.E.C.	Cooper's Hill
" 14	Esher	Esher
Thurs. " 19	Crystal Palace	Crystal Palace
Sat. " 21	M.C.C.	Winchmore Hill
Mon. " 30	Hornsey	Hornsey
Sat. June 4	Kensington Park	Winchmore Hill
" 11	Past v. Present	Winchmore Hill
Wed. " 15	Richmond	Richmond
Sat. " 18	Hampstead	Hampstead
Wed. " 22	Ealing	Ealing
Sat. " 25	Oxford University Authentics	Winchmore Hill
" July 2	Wanderers	Winchmore Hill
Wed. " 6	Hornsey	Winchmore Hill
Sat. " 16	Kensington Park	Wormwood Scrubbs
Tues. " 26	Surbiton	Surbiton

(Surbiton week.)

LAWN TENNIS CLUB.

The Annual General Meeting of the above club was held on January 27th.

The following gentlemen were elected to act as officers for the coming season:

Captain.—V. S. A. Bell.

Hon. Secretaries.—J. K. N. Marsh, J. Stirling Hamilton.

Committee.—S. Hey, H. Burrows, C. H. Barnes, F. E. Murray, J. W. Nunn, G. V. Bull, C. M. Pennefather, H. Walker.

MATCHES.

Date.	Name of Club.	Where Played.
Wed. May 4	Albemarle L.T.C.	Winchmore Hill
Sat. " 14	Southgate L.T.C.	Southgate
Wed. " 18	Hornsey L.T.C.	Hornsey
Thurs. " 19	Winchmore Hill L.T.C.	Winchmore Hill (Opponents' Ground).
Sat. " 21	Wanstead L.T.C.	Wanstead
" 28	Southgate L.T.C.	Winchmore Hill
Wed. June 1	Cooper's Hill L.T.C.	Cooper's Hill
Sat. " 11	Past v. Present	Winchmore Hill
Wed. " 15	Hornsey L.T.C.	Winchmore Hill
Sat. " 25	Clarence L.T.C.	Winchmore Hill
Wed. July 6	Albemarle L.T.C.	Beckenham
Sat. " 9	Wanstead L.T.C.	Winchmore Hill
" 16	Putney	Winchmore Hill
Tues. " 19	Winchmore Hill	Winchmore Hill

SWIMMING CLUB.

The Club opens the season with every prospect of success, for several good men have come up. Although the Club has lost W. Fay Bennett, one of the best men who ever swam or played polo for the Hospital, it is hoped that the members of the teams will, by practising often and playing well together, make up for the loss, and at the end of the season bring back the Water Polo Cup to its old home.

This being the first year of the Inter-Hospital Team Racing Shield, all swimmers are asked to turn up at the practices, so that a good team may be got together to represent the Hospital.

Weekly meetings are held on Thursdays at 4.30 throughout the Summer Session at the Fitzroy Baths, Tottenham Court Road. The baths are quite close to Gower Street station, which can be easily reached in a quarter of an hour from the Hospital.

Club tickets at the rate of 4d. each can be had from the Cloak Room at the Hospital.

The following fixtures have been arranged:

May 14th	Cambridge University	at Fitzroy Baths	5 p.m.
" 18th	Richmond S.C.	at Fitzroy Baths	9 p.m.
June 1st	Cambridge University	at Cambridge	
" 6th	Queen's Westminster	at Fitzroy Baths	9 p.m.
" 14th	Otter S.C.	at St. George's Baths	9 p.m.
" 17th	Richmond S.C.	at Richmond Baths	9 p.m.
" 29th	Queen's Westminster	at Westminster Baths	2 p.m.

Further fixtures are being arranged.

ASSOCIATION FOOTBALL CLUB.

The following are the results of the matches played by the Reserves:

		Played at	For	Agst.
Sat. 29th Jan.	Rahere Club	Away	3	1
Sat. 5th Feb.	Beckenham II.	Beckenham	3	3
Wed. 9th "	City of London School	Winchmore Hill	1	0
Sat. 12th "	Crouch End II.	Winchmore Hill	3	1
Sat. 19th "	Norsemen	Away	6	4
Sat. 26th "	Templers	Away	0	5
Tues. 1st Mar.	Forest School	Away	3	1
Sat. 5th "	Guy's Hospital II.	Winchmore Hill	0	2
Wed. 9th "	Royal School of Science	Winchmore Hill	2	5
Sat. 12th "	Ealing II.	Winchmore Hill	2	2

HOCKEY.

ST. BART.'S v. BLACKHEATH 3RD XI.

Played at Winchmore Hill on March 19th.

Blackheath unfortunately turned up short, and to make matters worse, rain fell heavily most of the time. In the first half the visitors were in our circle on several occasions, but could not score. H. R. Mayo and Muirhead scored a goal each for us. In the second half we put on four more goals, T. A. Mayo (2) and Jeaffreson (2) being responsible for them; but accurate play was impossible, and the match closed before time.

Team.—F. H. Parker, D. Jeaffreson, G. B. Nicholson (backs); F. Shout, T. A. Mayo, M. O. Boyd (halves); A. Muirhead, H. R. Mayo, R. Imthurn, A. Hallows, A. B. Edwards (forwards). Referee, E. C. Spray.

ST. BART.'S v. ROYAL OBSERVATORY.

Played at Blackheath on March 23rd.

Lost, 2—3. The following facts may account for this reverse:—(1) we played a man short throughout, and two short for some time; (2) the eccentricities of the ground; and (3) we did not take down an umpire.

Team.—D. Jeaffreson, H. Flint (backs); M. O. Boyd, T. A. Mayo, L. Orton (halves); A. H. Muirhead, J. A. Nixon, H. R. Mayo, A. Hallows, A. B. Edwards (forwards).

ST. BART.'S v. LONDON HOSPITAL.

Played at Winchmore Hill on March 30th.

The first inter-hospital match resulted in a win for us by 3 goals to 1. The first half consisted mostly of give-and-take play until just before half-time Mayo obtained the ball, made an excellent run, and scored. On resuming play, Philbrick, after a good run, scored for London. Shortly after this Nixon scored again for us from a scramble in front of goal. London then pressed our goal, but, owing to the good defence of Jeaffreson and Orton, failed to score again. Edwards

and Hallowes then took the ball well up to the London twenty-five; the latter sent on to Mayo, who put it through easily, leaving us victors of the last match of the season. For the Hospital, Jeaffreson, Orton, and Mayo played a good game.

Team.—D. Jeaffreson, H. Flint, G. B. Nicholson (backs); F. H. Parker, V. Bell, L. Orton (halves); J. A. Nixon, A. H. Muirhead, T. A. Mayo, A. Hallowes, A. B. Edwards (forwards). Umpires, L. Spry and A. H. Pollock.

The season's results read—Played 22, won 8, lost 11, drawn 3; goals for 61, against 66.

View Day.

THE annual View Day occurred on Wednesday, May 10th; fortunately the weather was most propitious, and in consequence the number of visitors was large, and the general air of festivity as marked as usual. The inspection of the wards and premises of the Hospital by the Governors took place with the traditional solemn ritual, and it would be hard to decide whether the appearance of the Beadle, the Treasurer's questions, or the imposing presence of the porter clearing the way for the Governors was the most impressive. When all the wards had been visited and all the necessary questions asked, and every patient had had the opportunity of lodging complaints against the Hospital in general and his own ward in particular, the more serious part of the day's functions was entered upon, and everybody settled down to the pleasant and stimulating process of testing how many cups of tea could be imbibed without disaster. The ward decorations were in all cases very successful, and in some quite bewildering in beauty of design. Flowers were abundant, and gave a very gay appearance to the wards. It would be invidious to make selections where all were so good, but we noticed especially Lucas, President, Martha, Colston, and Charity, for beauty and originality of design. In the last-named ward the well-known initials "J L" in forget-me-nots made a most striking and pleasing appearance, and we especially admired the colour scheme in Colston. Hope claimed attention by reason of its harmony of decoration and its pretty children. When all the wards had been inspected, all the available tea disposed of, the baby reigning in Martha for the time being sufficiently interviewed and admired, the dispensary thoroughly investigated, the crowd slowly dispersed, and another and very successful View Day was brought to its natural end.

The View Dinner.

TO View Day succeeds View Dinner; and by 7 o'clock the Treasurer, Almoners, Governors, the Staff, the Teaching and Junior Staffs and the prize-winners had assembled in the Great Hall to do justice to the feast prepared by Messrs. Ring and Brymer. The æsthetic sense was perhaps not so gratified as usual by the table decorations, which made up by profusion what they certainly lacked in harmony.

After the usual loyal toasts the Treasurer, Sir Trevor Lawrence, rose to propose the toast of the evening, "Prosperity to St. Bartholomew's Hospital, and health and ease to the poor patients." The speech accompanying this toast is always listened to with much interest, since, like the Premier's speech at the Lord Mayor's banquet, it usually contains a statement of the policy and plans of the powers that be. Almost equal in interest to the things that are said on such occasions are the things which are left out.

Sir Trevor gave the numbers of the patients treated in the various departments as follows:

	1897.		1896.
In-patients	6,393	...	6,840
Out-patients.....	15,884	...	14,770
Casualty patients.....	128,517	...	133,817
Maternity cases	1,776	...	1,723

In the maternity department there had been an increase in the plural births—35 cases of twins, and on one occasion triplets. 1771 patients had been helped by food, surgical instruments, and clothes from the Samaritan Fund. This was not a charity dinner, but he felt sure that anyone who wished to make a donation could not do

better than help this most useful fund. There had been 996 convalescent patients sent to Swanley, and 96 to other homes.

He was happy to be able to give a favorable account of the income and property of the Hospital. Turning to the changes that the year had brought, he said that the resignation of Sir Thomas Smith had been received with great regret, but it was gratifying to remember that as Consulting Surgeon he was still one of our Staff, and that he was still engaged in active professional work. His place had been admirably filled by Mr. Walsham. He offered his congratulations to Mr. D'Arcy Power on his election to the Staff, and also to his father, Mr. Henry Power, so long our distinguished and popular Ophthalmic Surgeon. He referred in the warmest terms to the admirable work of Mr. Berry, and expressed his pleasure at the fact that we were not to lose his services as a teacher. This remark was received with a loud and lively demonstration of satisfaction, as was his next remark as to a probable recognition of his services by the Governors in the future. As Mr. Berry's successor we had secured a thoroughly competent man in Mr. Waring. There was one more resignation to announce, that of Dr. Shore, who had filled the difficult and exacting post of Warden with energy and ability.

He then referred to the changes in the East Wing—the new beds and lockers. Next year it was proposed to turn attention to the new wing and provide it with fire-escapes. The Hospital arrangements would then meet with the approval of Commander Wells in that respect. He thought that we might consider the difficulties with respect to the Christ's Hospital site at an end, and that we should be able to meet the urgent need for expansion. Coming to the work done by the various departments, Sir Trevor commented on the admirable services of the Medical and Surgical Staff, and on the excellence of the Nursing Staff. In this latter respect we laboured under two disadvantages, for the Nursing Staff were possessed of such personal attractions that they were constantly being removed by marriage, and of such high professional qualifications that they were always being tempted away to other institutions. He could not speak too highly of their devotion to their work. The Administrative Staff, under the tactful and skilled guidance of Mr. Cross, maintained their high reputation, and in his son, Mr. H. W. Cross, we had found an Assistant Secretary of great promise. He concluded that we had every reason to be satisfied and proud of the old Hospital.

Sir Sidney Waterlow then rose to propose the health of "The Medical and Surgical Staff." He hoped that within those walls he would never be regarded as a stranger, and congratulated the Treasurer on the lucid account given of the work done here. The success of the work must depend largely on the ability, intelligence, and conscientiousness of the Medical and Surgical Staff. It was twenty-five years since he was elected Treasurer, and he had watched their promotion to their present distinguished position. While we can secure such talent the future of St. Bartholomew's Hospital is secured. He thanked them for the assistance rendered him in the establishment of a hospital at Cannes, and in conclusion referred to the loss we had sustained in the resignation of Sir Thomas Smith.

The toast having been drunk with enthusiasm, Dr. Church rose to reply for the Medical side. He expressed great pleasure at the toast having been placed in Sir Sidney Waterlow's hands, and not in those of an "outsider," however distinguished; for only a man in his position could fully estimate the work of the Staff. During his tenure of the office of Treasurer there had been greater internal changes than in any previous reign. He thanked the Governors for the generous way in which their requests on behalf of the School had been fulfilled. Not all had been, but it was not the will, but the means that were lacking. The more we got, the more we asked. "Walking the hospitals" had sometimes been regarded as much the same as the formal visit paid by the Governors to-day. In reality the work of a medical student involved arduous and consistent clinical study.

Mr. Willett then replied for the Surgical side. He referred to the recent changes in the Staff, which had put him in a position to reply for this toast. It was thirty-three years since he became Assistant Surgeon, following Sir William Lawrence's resignation. He was now Senior Surgeon, but he felt like the ancient Romans, who in the hour of their glory were reminded of their mortality. Having congratulated Mr. D'Arcy Power on his election, Mr. Willett proceeded to speak in the highest terms of Mr. Berry's work as a teacher and registrar, and said how warmly he would be welcomed at the Staff table. He then remedied a noteworthy omission in the Treasurer's speech by eulogising the work of the Junior Staff, on whose trustworthiness and persistent industry he said the Visiting

Staff had to rely so much. As to the Nursing Staff, Mr. Willett commented on the fact that the same three Sisters administered in his wards as when he first became Surgeon here, and that he found them now, as ever, most energetic and devoted to their work. The past year or two had seen a great development in one department—the use of the X rays under the skilled superintendence of Dr. Lewis Jones. He concluded an effective and interesting speech by saying that this recognition of the labours of himself and his colleagues would be a great encouragement in their daily work in the wards.

Mr. Justice Grantham, in proposing the health of the Treasurer and Almoners, said he was more accustomed to sum up or to pass sentence than to make speeches. He did not know which he was expected to do now, but he felt he had come under false pretences. For on a "View Day" he expected to get a view of some difficult operation by Mr. Willett, or some great cure effected by Dr. Church, or at least a view of those interesting ladies of whom he had heard so much. He concluded by congratulating the Treasurer on the work of the Hospital, and the Hospital on having as its Treasurer one bearing the honoured name of Lawrence.

The Treasurer having briefly responded, Mr. Coleman replied for the Almoners. He claimed that in one respect he stood apart from his colleagues, in that he had once been on the Staff; but in whatever capacity it was a real pleasure to him to devote his services to the Hospital. He closed his speech by proposing the health of the visitors, a toast which was acknowledged by Sir John Bridge. Sir Henry Roscoe, in proposing the health of the prize-winners, said that he based his claim to do so as a teacher of medical students for thirty years, and as a successor at London University of Sir James Paget. He could speak highly from personal experience of the work turned out here. This toast having been suitably acknowledged by Mr. Auden, as Lawrence Scholar, the proceedings closed.

During the evening Mrs. Helen Trust sang three songs with her accustomed grace and finish, and M. Tivadar Nachez played five violin solos with his usual *verve*. Mr. S. Liddle acted as accompanist.

The Rahere Lodge, No. 2546.



AN ordinary meeting of the Rahere Lodge was held at Frascati's Restaurant on Tuesday, 10th May, 1898. Bro. W. J. Walsham, W.M., in the chair. Bro. Launcelot E. Towers was elected a joining member. Messrs. J. A. O. Briggs, Arthur Heath, and J. Stewart Mackintosh, jun., were elected members of the Lodge, and were afterwards initiated into Masonry by the W.M. Bros. Christopherson, Carnall, and Hoyland were passed to the second degree by W. Bro. West. A sum of thirty guineas was voted from the Lodge funds to the Centenary Festival of the Royal Masonic Institution for Boys. W. Bro. T. G. A. Burns was elected W.M. for the ensuing year; W. Bro. Clement Godson, M.D., was elected Treasurer; and Bro. Madden was re-elected Tyler. W. Bro. Gilbertson was nominated with Bros. Cross and West as Auditors. It was decided that the Lodge should offer itself for election as a perpetual member of the correspondence circle of the Quatuor Coronati Lodge. Between fifty and sixty brethren and their guests afterwards dined together.

Members of the Lodge are requested to take notice that the Installation Meeting of the Lodge will be held in the Great Hall of St. Bartholomew's Hospital on the second Tuesday in June.

The Month's Calendar.

[Secretaries of Clubs, &c., are requested to co-operate in making this list as complete as possible by forwarding notices of forthcoming events to the Editor.]

MAY.

- Tues. 17th.—Dr. Gee's and Mr. Langton's duty.
Wed. 18th.—Mr. Willett's Clinical Lecture. St. Bart's L.T.C. v. Hornsey L.T.C. at Hornsey.
Thurs. 19th.—Examination for Lawrence Scholarship begins. St. Bart's C.C. v. Crystal Palace C.C. at Crystal Palace. St. Bart's L.T.C. v. Winchmore Hill L.T.C. at Winchmore Hill.

- Fri. 20th.—Sir Dyce Duckworth's and Mr. Marsh's duty. Sir Dyce Duckworth's Clinical Lecture.
Sat. 21st.—St. Bart's C.C. v. M.C.C. at Winchmore Hill. St. Bart's L.T.C. v. Wanstead at Wanstead.
Tues. 24th.—Dr. Hensley's and Mr. Butlin's duty.
Wed. 25th.—Mr. Willett's Clinical Lecture.
Fri. 27th.—Dr. Brunton's and Mr. Walsham's duty. Dr. Hensley's Clinical Lecture.
Sat. 28th.—St. Bart's L.T.C. v. Southgate at Winchmore Hill.
Mon. 30th.—St. Bart's v. Hornsey at Hornsey.
Tues. 31st.—Dr. Church's and Mr. Willett's duty.

JUNE.

- Wed. 1st.—Mr. Marsh's Clinical Lecture. St. Bart's L.T.C. v. Cooper's Hill at Cooper's Hill.
Fri. 3rd.—Dr. Gee's and Mr. Langton's duty. Dr. Brunton's Clinical Lecture. Examination for Matthews Duncan Medal.
Sat. 4th.—St. Bart's C.C. v. Kensington Park at Winchmore Hill. St. Bart's L.T.C. v. Connaught at Chingford.
Tues. 7th.—Sir Dyce Duckworth's and Mr. Marsh's duty. St. Bart's L.T.C. v. Albemarle at Winchmore Hill.
Wed. 8th.—Mr. Butlin's Clinical Lecture.
Fri. 10th.—Dr. Hensley's and Mr. Butlin's duty. Dr. Church's Clinical Lecture.
Sat. 11th.—Past v. Present at Winchmore Hill. St. Bart's L.T.C. v. Clarence at Brixton. Amalgamated Clubs' Dinner at Holborn Restaurant.
Tues. 14th.—Dr. Brunton's and Mr. Walsham's duty. Meeting of Rahere Lodge in the Great Hall.
Wed. 15th.—Mr. Butlin's Clinical Lecture. St. Bart's C.C. v. Richmond at Richmond. St. Bart's L.T.C. v. Hornsey at Winchmore Hill.

Reviews.

LECTURES ON RENAL AND URINARY DISEASES. By Robert Saundby, M.D. Edin., F.R.C.P. Lond.; second edition, 1896.

At the risk of being thought pedantic, we venture to quarrel with the title of the book before us. It is a misnomer, more than a third of the work being devoted to diabetes, a disease which is neither renal nor urinary. We are aware that the author introduces the term "urinary" to cover the lectures on diabetes, but surely a more fitting title, and a less deceptive one, would be *Lectures on Renal Diseases and Diabetes*—more fitting for the reason just given, and less deceptive because the student whom the present title of the book warrants in expecting an account of, say such important a urinary disease as cystitis, would seek for it in vain. Fortunately the book still retains the name of "Lectures;" this should warn the reader against considering it in any sense a text-book. Such a common disease as nephropotosis, for instance, finds no place in it. Among the early chapters in the section on Bright's disease are some of special value. Foremost in this respect is that upon *retinal changes*; this is excellent, and undoubtedly forms the best account we possess of this important subject. As Dr. Saundby reminds us, a systematic and careful examination of the fundus oculi in cases of Bright's disease is particularly useful as an aid in prognosis. Scarcely less valuable are the lectures on the pathological relations of tube-casts and cardio-vascular changes. These preliminaries over, the author is confronted by the old difficulty of classification. We cannot regard his attempt at a solution as successful. The pathological division of cases into "parenchymatous" and "interstitial" cannot be relied upon ante mortem. Granted,—but the alternative offered us, "infective" and "lithæmic" (we pass over Dr. Saundby's third group of "obstructive" cases, as being a convenient category in which to place those that are secondary to diseases of the urinary tract), seems equally unsatisfactory. For we are led beyond our facts in granting that all cases of nephritis not caused by the infective fevers are due to "the presence of uric acid in the blood, and to the prolonged effects of its elimination through the kidneys," which is the author's ætiological definition of his term "lithæmic." As might be expected, we notice a plentiful use of the word "dyscrasia" to explain cases which this definition scarcely seems to cover. Thus it seems unnecessary, in the absence of proof to the contrary, to assume that the damaged kidney in a case of nephritis due to lead is not the work of the poison itself, but is the result of the lead causing "an accumulation of uric acid in the system."

Similarly with the nephritis set up by such a drug as turpentine. Indeed, beyond the bare division of cases into acute and chronic—a division which is itself often difficult to maintain—the question arises, is it necessary to divide them further?

In a work that professes special attention to the clinical aspect of its subject, we could have wished for a fuller account of the various uræmic conditions met with—those important manifestations of chronic kidney disease for which patients seek advice previous to, or it may be without ever developing, the more unequivocal symptoms of dropsy, frequent or scanty micturition, &c. Thus the gastro-intestinal group of uræmic symptoms is dismissed in half a dozen lines, whereas we have seen cases, both of persistent vomiting and profuse diarrhoea, going on to fatal terminations without any other signs leading to the diagnosis of the extreme degree of granular kidney found post mortem. An account of uræmic skin eruptions, instead of a bald mention of their occurrence, would be valuable. In the cerebral group we find no note (apart from hemiplegia) of uræmic aphasia.

We can heartily commend the plan of illustrating the text by nearly a hundred clinical cases, which are all of them helpful. There are also thirty useful pages on the clinical examination of the urine. The ophthalmoscopic plates are as good as these productions usually are.

In the lectures on diabetes we feel the author is treading upon ground specially familiar to him. Our only regret is his inability to "show us any new thing." In the historical section we miss the name of Cruickshank, to whom we owe the first chemical test for sugar in diabetic urine. And in the account of phloridzin diabetes we are told that in this condition glycosuria occurs without hyperglycæmia, the formation of the sugar being put down to the action of the renal epithelium; but Coolen, and afterwards Pavy, proved that the ingestion of phloridzin was followed by excess of sugar in the blood; so we still know of no exception to the rule that glycosuria and hyperglycæmia are co-existent, the former being the sign of the latter. The Bradshaw Lecture for 1890, on the morbid anatomy of diabetes, is inserted (revised); but even here, where the author is most of all at home, our regret repeats itself—effects come, but causes linger,—and it all amounts to so little. Of no pathological condition do we know more associated facts than of diabetes, yet for none are our facts of less value towards any practical application. But then that is not Dr. Saundby's fault.

THE YEAR-BOOK OF TREATMENT FOR 1898. (Cassell and Co., Ltd.)

We welcome the fourteenth annual issue of this useful work. Its scope is, of course, wider than its title implies, including as it does a good deal more than treatment. It is, in fact, a critical summary of the important advances in the various branches of medicine and surgery; the information being supplied in a readable form by reliable authorities. We notice that Mr. Henry Power contributes the article on "Diseases of the Eye," Mr. Walsham that on "Orthopædic Surgery," and Dr. Garrod that on "Gout, Rheumatism, and Rheumatoid Arthritis." This book is all but indispensable to those who desire to keep themselves acquainted with what is being done and said in the various departments of medicine.

CLINICAL LECTURES ON URINE, by J. Rose Bradford, M.D., F.R.C.P., F.R.S. (London: The Medical Publishing Co., Ltd. Price 2s.)

These admirable lectures are reprinted from the *Clinical Journal*, and will be found very useful in their present more compact form. Dr. Rose Bradford's name is a sufficient guarantee that they are at once thoroughly scientific and practical, for he is well qualified to speak both from the clinical and the experimental standpoint. His own share in advancing our knowledge of the physiology of the kidney is by no means a slight one, for we owe to him researches on the vaso-motor nerves of this organ and the part played by it in general metabolic processes.

Dr. Clifford Beale's translation of Von Jaruntowsky's monograph on SANATORIA FOR CONSUMPTIVES (London: The Rebm Publishing Co., Ltd.) affords a concise and useful manual on a very important subject, of which we fear little is known in this country. The practitioner who has the responsibility of advising a patient as to climatic treatment will find this a useful book of reference.

We have received from E. and S. Livingstone a book (price 2s. 6d.) entitled DISEASES OF THE SKIN, by "Utile quod Facias." We must confess to a very strong objection to use of a *nom-de-plume* in scientific text-books. If a book is worth writing at all the author need not be ashamed of putting his name to it. Incidentally we call

a charming piece of English from page 11: "Excoriation is a partial removal of the epidermis. They are frequently due to scratching."

Mr. J. A. Kempe's little book on DISEASES OF THE EYE (Edinburgh: E. and S. Livingstone, price 1s. 6d.) is a clear *résumé* of the important points of this subject, which may usefully serve for purposes of revision just prior to an examination.

New Productions.

IMPROVED CLINICAL THERMOMETERS.—We have received a sample of new patent clinical thermometers which Messrs. Maw, Son and Thompson are now putting upon the market. Hitherto the great disadvantage of all forms of thermometers has been the difficulty experienced in shaking down the index after use; especially is this the case with the more rapidly registering instruments, on account of their extremely fine bores. By means of the new patent this difficulty is obviated. Its efficiency may be readily tested in the following way:—Take one of the old forms of thermometers and one of the new patents, and force the mercury in each up to about 105°; then hold the two together side by side in one hand and shake them in the ordinary way. It will be found that after one shake of the hand the mercury in this new instrument has gone down about twice the distance that it has in the other. The new principle is adapted to all forms of clinical thermometers, whether "½ minute," "1 minute," ordinary, or lenticular, &c., and the difference between the price of the new and old is only 8s. per dozen. We can vouch for their convenience from personal experience.

THE ALFORMANT LAMP.—Wholesale agents, A. & M. Zimmermann, 9 and 10, St. Mary-at-Hill, E.C.

Formalin is a drug which has come rapidly into use in various directions. At this Hospital we are familiar with it as a preservative agent for museum specimens; and the vapour of formaldehyde given off from polymerised dry formalin is shown to be a powerful and effective disinfectant,—10 grammes of formalin being enough for a room of 1000 cubic feet. We have already (August, 1897) referred to the convenience of the Alformant lamp for distributing the gas; Messrs. Zimmermann have now introduced two sizes, the one marked A for use in hospitals and large rooms, and the other marked B for ordinary dwelling-rooms. By such means the whole process may be readily carried out.

LEVICO WATER. (From the same agents, price 1s. 8d. per bottle.)—This is a natural water from the Tyrol, containing arsenious acid and sulphates of iron. There are two distinct springs; from one is bottled the Levico mild, and from the other, which is much richer, is obtained the Levico strong. Both these waters are bottled without dilution as they issue from the two springs, and do not undergo any process whatever. This would seem a satisfactory method of administering two important drugs, but we must dissent from the statement that it is "a very suitable and convenient form of arsenical medication for domestic use." Under no circumstances is arsenic a drug suitable to be used except under medical advice.

Appointments.

ATTFIELD, D. H., M.B., B.C., D.P.H.(Cantab.), appointed Medical Officer of Health for the Watford Urban District.

Box, S. L., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Western General Dispensary.

DYSON, M. G., M.R.C.S., L.R.C.P., appointed Resident Assistant Medical Officer at the St. John's Road Workhouse and Infirmary of St. Mary Islington.

PARKER, H. T., M.D., B.S.(Lond.), D.P.H., appointed Medical Inspector of Egyptian Prisons.

ROBERTSON, F. W., M.B., B.S.(Lond.), M.R.C.S., L.R.C.P., appointed Medical Officer in charge of the Casualty Department at the East London Hospital for Children, Shadwell.

SHELLY, C. E., M.D.Camb., M.R.C.P.Lond., M.R.C.S., has been appointed Honorary Physician by the Hertford and Ware Joint Hospital Board.

TASKER-EVANS, J. T., M.D.Aberd., L.R.C.P.Lond., M.R.C.S., has been appointed Honorary Physician by the Hertford and Ware Joint Hospital Board.

Examinations.

CAMBRIDGE FINAL M.B., Part i.—H. Boulton, W. D. Harmer, K. Hay, A. C. Jordan, T. W. Letchworth, H. F. Parker, S. P. Pollard, E. Sewell, A. N. Ware. Part ii.—E. A. C. Matthews, A. E. Naish, J. E. Sandilands, Hon. G. H. Scott.

M.D.DURHAM.—E. C. Bridges.

FINAL M.B.Durham.—H. E. M. Baylis, F. W. Crossman, H. J. Godwin, R. C. J. Stevens, P. E. Turner, M. D. Wood.

FINAL B.S.Durham.—H. E. M. Baylis, F. W. Crossman, R. C. J. Stevens, P. E. Turner, M. D. Wood.

SECOND CONJOINT.—*Anatomy and Physiology*.—C. H. D. Robbs, B. S. O. Maunsell, H. R. Humby, G. J. Humphreys, J. C. Sale, A. H. John, A. E. Thomas, A. H. Bostock, C. S. Hawes, T. E. C. Cole, W. R. Read.

FIRST CONJOINT.—*Chemistry*.—E. O. Hughes, E. W. Däll, E. W. Alment, J. O. Bennett, R. J. P. Thomas, H. B. Butler, E. H. G. Duncan, W. C. F. Harland, P. J. Martin, A. O'Neill, H. E. Scoones, W. H. Scott, H. A. Woodruffe.

FIRST CONJOINT.—*Biology*.—E. W. Alment, J. O. Bennett, R. J. P. Thomas, G. L. J. Acres, G. H. Adam, M. O. Boyd, N. A. W. Conolly, J. Corbin, S. E. Crawford, W. R. L. Drawbridge, A. Hallows, C. W. C. Harvey, F. Harvey, E. L. Hodgson, R. Holtby, F. W. Jackson, C. S. Kingston, E. Leverton-Spry, N. MacFadyen, A. H. Muirhead, C. Murdoch, T. C. Neville, C. V. Nicoll, A. S. Petrie, J. M. Plews, P. M. Rivaz, W. R. Square, H. E. Stanger-Leathes, L. R. Tosswill.

FIRST CONJOINT.—(*Old Regulations*) *Elementary Physiology*.—W. R. Read.

FINAL L.S.A.—*Midwifery*.—P. Cator, N. Walmisley.

FINAL M.R.C.S. AND L.R.C.P.—The following have passed all parts of this examination, and have received their Diplomas:—J. G. F. Hosken, F. L. Provis, J. E. Robinson, E. W. Woodbridge, W. W. Lacey, R. Raines, E. A. C. Matthews, H. A. Levison, H. G. Harris, C. G. Watson, S. A. Millen, A. L. Scott, C. F. Winkfield, L. L. Allen, P. P. Lal Atal, A. E. Hodgkins, A. E. Smithson, H. A. Scholberg.

Correspondence.

To the Editor of the St. Bartholomew's Hospital Journal.

THE SEVENTH DECENNIAL CONTEMPORARY CLUB.

DEAR SIR,—Will you kindly allow us, through the medium of your columns, to acquaint the members of this club of the result of the collection raised in order to present a wedding present to Mr. Bowlby?

The total amount collected was £65 18s. and after deducting £2 4s. for printing and postage £63 14s. remained. With this sum, in consultation with Mr. and Mrs. Bowlby, we have bought a set of fine open filigree Silver Baskets for table decoration, consisting of one large basket and two pairs of smaller ones. These it is proposed to hand over formally to Mr. Bowlby at the next

Annual Dinner, on the first Wednesday in July (6th), when we hope for a record attendance of the members of the club.

Yours faithfully,

HOWARD TOOTH,
EDGAR WILLET, } Hon.
F. C. WALLIS, } Treasurers.

To the Editor of the St. Bartholomew's Hospital Journal.

THE ATHLETIC CLUBS.

DEAR SIR,—The past and present members of the Hospital Athletic Clubs who subscribed for a wedding present to Mr. Bowlby will be interested to hear that the amount raised was £86 15s. After deducting £1 9s. 6d. for expenses of printing and postage there remained £85 5s. 6d.

This sum has been expended in accordance with the wishes of Mr. Bowlby in purchasing, first, a china dinner service, and secondly, a silver tray and claret jug. It is intended to present these to Mr. Bowlby on the occasion of the dinner of the Amalgamated Clubs, which is to be held on Saturday, June 11th.

Faithfully yours,

On behalf of the Committee,
THE HON. TREASURER.

Births.

GRUMMITT.—On April 20th, at Kingsbridge, South Devon, the wife of C. C. Grummitt, M.R.C.S., L.R.C.P., of a daughter.

HOLDEN.—On April 27th, at 168, Castle Hill, Reading, the wife of George Herbert Rose Holden, M.A., M.D.Cantab., of a son.

SEGUNDO.—On May 3rd, at Brook Street, Hanover Square, W., the wife of C. S. de Segundo, M.B., B.S.Lond., of a son.

Marriages.

BOWLBY—MOSTYN.—On Tuesday, April 12th, at All Saints' Church, Buckworth, by the Ven. Archdeacon Vesey, D.D., of Huntingdon, assisted by Rev. Lionel Majendie, B.A., Anthony Alfred Bowlby, F.R.C.S., of 24, Manchester Square, to Maria Bridget, daughter of the Hon. and Rev. H. W. Mostyn, Rector of Buckworth, Hunts.

FURNIVALL—BUTLIN.—On 23rd April, at St. Andrew's, Well Street, by the Rev. W. T. Houldsworth, Vicar, assisted by the Rev. E. Grose Hodge, Rector of Holy Trinity, Marylebone, Percy Furnivall, F.R.C.S., of 39, Welbeck Street, Cavendish Square, W., to Olive Mary, elder daughter of Henry Trentham Butlin, F.R.C.S., of 82, Harley Street, W.

MURRELL—WILLIAMSON.—On April 26th, at St. John's Church, Putney, by the Rev. A. K. Hurley, George Frederick Murrell, M.B.Lond., of Craven Road, Reading, to Rose Annie, second daughter of John Williamson, of Beechhurst, Putney Common, Surrey.

SIMMONS—MACKRELL.—On 21st April, at St. Andrew's Church, Ashley Place, S.W., by the Hon. and Rev. J. S. Northcote, Vicar, Percy Arden Simmons, of Oxford, Kent, to Constance Mary, elder daughter of the late Alfred Sextus Mackrell, of 2, Manchester Square, W., and Crouch, Sevenoaks.

THORNE THORNE—HOUGHTON.—On the 27th ult., at St. Peter's, Old Woking, by the Rev. F. J. Oliphant, M.A., Vicar, assisted by the Rev. W. F. T. Hamilton, M.A., Berthold Bezly, eldest son of Sir Richard Thorne Thorne, K.C.B., F.R.S., to Ruth Golding, daughter of the late John Houghton, of Liverpool, and of Mrs. Houghton, of Poundfield, Old Woking.

Death.

GRÜBER.—On March 9th, P. O. Grüber, B.A.Cantab., aged 27, of phthisis.

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